Ontario

Ministry of Health and Long-Term Care

Inspection Report under the Long-Term Care Homes Act, 2007

Ministère de la Santé et des Soins de longue durée

Rapport d'inspection sous la Loi de 2007 sur les foyers de soins de longue durée

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

Division de la responsabilisation et de la performance du système de santé
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Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Feb 19, 2015	2014_282543_0027	S-000478-14	Resident Quality Inspection

Licensee/Titulaire de permis

THE BOARD OF MANAGEMENT OF THE DISTRICT OF NIPISSING WEST
100 Michaud Street STURGEON FALLS ON P2B 2Z4

Long-Term Care Home/Foyer de soins de longue durée

AU CHATEAU
100 MICHAUD STREET STURGEON FALLS ON P2B 2Z4

Name of Inspector(s)/Nom de l'inspecteur ou des inspecteurs

TIFFANY BOUCHER (543), MONIQUE BERGER (151), VALA MONESTIMEBELTER (580)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Resident Quality Inspection inspection.

This inspection was conducted on the following date(s): November 11th-21st, 2014

During the course of the inspection, the inspector(s) spoke with Administrator, Administrator Assistant, Human Resource Manager, Registered Staff (RNs and RPNs), Personal Support Workers (PSW), Environmental Service Manager, Dietitian, Staff Development/Infection Control Lead and Occupational Health Co-ordinator, Food Service Supervisor, Food Service Worker (FSW), Residents and family members.

The following Inspection Protocols were used during this inspection:
Accommodation Services - Maintenance
Continence Care and Bowel Management
Dignity, Choice and Privacy
Dining Observation
Falls Prevention
Family Council
Hospitalization and Change in Condition
Infection Prevention and Control
Medication
Minimizing of Restraining
Nutrition and Hydration
Pain
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Recreation and Social Activities
Reporting and Complaints
Residents' Council
Skin and Wound Care
Sufficient Staffing

During the course of this inspection, Non-Compliances were issued.

10 WN(s)
4 VPC(s)
6 CO(s)
0 DR(s)
0 WAO(s)

NON-COMPLIANCE / NON - RESPECT DES EXIGENCES	
Legend WN – Written Notification VPC – Voluntary Plan of Correction DR – Director Referral CO – Compliance Order WAO – Work and Activity Order	Legendé WN – Avis écrit VPC – Plan de redressement volontaire DR – Aiguillage au directeur CO – Ordre de conformité WAO – Ordres : travaux et activités
Non-compliance with requirements under the Long-Term Care Homes Act, 2007 (LTCHA) was found. (a requirement under the LTCHA includes the requirements contained in the items listed in the definition of "requirement under this Act" in subsection 2(1) of the LTCHA). The following constitutes written notification of non-compliance under paragraph 1 of section 152 of the LTCHA.	Le non-respect des exigences de la Loi de 2007 sur les foyers de soins de longue durée (LFSLD) a été constaté. (une exigence de la loi comprend les exigences qui font partie des éléments énumérés dans la définition de « exigence prévue par la présente loi », au paragraphe 2(1) de la LFSLD. Ce qui suit constitue un avis écrit de non-respect aux termes du paragraphe 1 de l'article 152 de la LFSLD.

WN #1: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 3. Residents' Bill of Rights

Specifically failed to comply with the following:

s. 3. (1) Every licensee of a long-term care home shall ensure that the following rights of residents are fully respected and promoted:
1. Every resident has the right to be treated with courtesy and respect and in a way that fully recognizes the resident's individuality and respects the resident's dignity. 2007, c. 8, s. 3 (1).

s. 3. (1) Every licensee of a long-term care home shall ensure that the following rights of residents are fully respected and promoted:
8. Every resident has the right to be afforded privacy in treatment and in caring for his or her personal needs. 2007, c. 8, s. 3 (1).

Findings/Faits saillants :

1. On November 13, 2014, Inspector #151 observed staff storing resident equipment such as a resident lift and a commode in a resident's room, encroaching on resident's space. The Inspector asked the PSW why the lift and commode were in the resident's room who stated, "because we have no other area to store this equipment".

Consequently, the licensee failed to ensure that the resident was treated with courtesy and respect and in a way that fully recognizes the resident's individuality and respects the resident's dignity. [s. 3. (1) 1.]

2. On November 12, 2014, Inspector #543 observed the RPN administering an Insulin injection to a resident in the dining room. The RPN lifted the resident's shirt, exposing the resident's abdomen. Other residents were observed in the dining room at that time.

Inspector #543 was approached by the Administrator regarding the above incident and stated that all RPNs had been notified in the past, that under no circumstances would they administer any injections/treatments in the dining room. The Administrator confirmed that the practice of administering treatments in the dining room is cause for disciplinary action.

On November 18, 2014, Inspector #151 observed medication administration on one of

the units of the home. The inspector observed that resident #212 was asked by the RPN to come to the empty living room in order to give them their morning Insulin in private. This resident had been seated with other residents in the hallway by the elevator. This resident protested having to move as it was not something they usually asked of them. Inspector #151 asked this resident where staff typically administer their Insulin injections. The resident responded that the staff will give the Insulin wherever they found them, in their room, in the lounge or in the dining room.

On November 13, 2014, Inspector #151 observed that the home's physician was making rounds on one of the units. The inspector observed the following; the physician listened to a resident's chest (which involved lifting the resident's shirt) at the nursing station. Also in the area were the Inspector, the RN, the physician's aide, and 5 residents sitting in chairs at the desk. The physician went to a resident sitting in one of the chairs around the nursing station and with the help of the home's physician aide, lifted the resident's shirt up to their neck to visualize the resident's back.

The above incidents were reported to the Administrator who stated that he also saw this as inappropriate and added that the home provides the physician with a special room for this or the physician could have examined the residents in their rooms. The Administrator stated that he would be speaking to the physician.

On November 13, 2014, Inspector #151 was seated at the nursing desk on Unit A for approximately 3 hours reviewing health care records. The Inspector noted that two baby monitor receivers were at the desk and that they were in the "on" position. The Inspector was able to hear what was said in resident to staff and resident to visitor exchanges and was able to hear the residents move about in their rooms.

Inspector #151 asked the RN why the monitors were needed. The RN stated that one resident has frequent falls and the monitor alerts staff as to when the resident is moving about their room. A bed and chair alarm was tried but the resident kept pulling it off.

Another resident frequently wanders, the monitor allows staff to hear when this resident leaves the room.

The receiver for the monitor is located on an open shelf that adjoins and is open to the dining room, small living room and both corridors. It is not even in the privacy of the nursing station. All staff, residents and visitors in the hallways, lounge or dining room can overhear what is being received.

A discussion ensued as to the residents' right to privacy and that this included acoustic privacy. Inspector #151 spoke with the RN who confirmed that all the call bell systems on every resident unit had the ability to eavesdrop on residents but stated that the intent of eavesdropping was to hear the resident when they got up and to prevent falls and wandering.

The Inspector spoke to the Administrator, who understood the privacy issues related to the baby monitors. The issue with the call bells is the same issue, that of resident privacy.

The Inspector spoke to the Infection Control Nurse in charge who stated that they had good intentions but now sees how it transgresses the resident's right to privacy. The Infection Control Nurse intends to ask other homes how they monitor residents who wander or who are at risk for falls.

On November 14, 2014, the RN came to debate the baby monitor issue with Inspector #151 and advised that the building's entire call bell system has the ability to listen in on what was is going on in the rooms and that it was turned on especially on nights.

Consequently, the licensee failed to ensure that the resident had the right to be afforded privacy in treatment and in caring for his or her personal needs. [s. 3. (1) 8.]

Additional Required Actions:

CO # - 001 will be served on the licensee. Refer to the "Order(s) of the Inspector".

WN #2: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 6. Plan of care

Specifically failed to comply with the following:

s. 6. (1) Every licensee of a long-term care home shall ensure that there is a written plan of care for each resident that sets out,
(a) the planned care for the resident; 2007, c. 8, s. 6 (1).
(b) the goals the care is intended to achieve; and 2007, c. 8, s. 6 (1).
(c) clear directions to staff and others who provide direct care to the resident. 2007, c. 8, s. 6 (1).

s. 6. (7) The licensee shall ensure that the care set out in the plan of care is provided to the resident as specified in the plan. 2007, c. 8, s. 6 (7).

s. 6. (8) The licensee shall ensure that the staff and others who provide direct care to a resident are kept aware of the contents of the resident's plan of care and have convenient and immediate access to it. 2007, c. 8, s. 6 (8).

s. 6. (9) The licensee shall ensure that the following are documented:
1. The provision of the care set out in the plan of care. 2007, c. 8, s. 6 (9).
2. The outcomes of the care set out in the plan of care. 2007, c. 8, s. 6 (9).
3. The effectiveness of the plan of care. 2007, c. 8, s. 6 (9).

Findings/Faits saillants :

1. Inspector #543 reviewed resident #60621's care plan in regards to restraints/PASD which only identified the use of a table-top. This care plan identified that this device is used for resident #60621's need to control poor posture. The PASD-tabletop is to be untied on wheelchair for meals only and that staff are to check on this resident hourly and release the PASD to reposition every 2 hours and as required. Inspector #543 observed resident #60621 wearing a lap belt. There is no mention of a lap belt in this resident's care plan.

Inspector #543 spoke with the RN Supervisor regarding this resident's care plan not addressing the use of a lap belt, who confirmed that the care plan should have identified this resident's need for a lap-belt.

Consequently the licensee failed to ensure that the plan of care set out clear direction to staff and others who provide direct care to resident #60621.

Inspector #151 reviewed resident health care records. The Inspector noted that several care plans did not provide clear direction to staff providing care as follows:

Resident #60621's plan of care identified that this resident required a pureed diet related to risk of choking as evidenced by the fact that this resident pockets "chunks" of food and will eventually spit the food out. The goal for this resident was to "prevent/minimize choking", however the intervention stated: "Offer cheese and crackers for pm snack". The Inspector interviewed the Dietitian who confirmed that the offer of cheese and crackers has been outdated for some time.

Resident #40708's plan of care identified that a resident has the following intervention: "foley catheter in place to promote healing and keep them dry". An inspector observation and an interview with the RN confirmed that the resident has no foley catheter in place.

Resident #40186's plan of care identified that a resident has the following intervention: "foley catheter in place to promote healing and keep them dry". An Inspector observation and an interview with the RN confirmed that the resident has no foley catheter in place.

Resident #40820's plan of care identified that a resident has the following intervention: "foley catheter in place to promote healing and keep them dry". An Inspector observation and an interview with the RN confirmed that the resident has no foley catheter in place.

Resident #60199's plan of care identifies that a resident has the following intervention: "foley catheter in place to promote healing and keep them dry". An Inspector observation and an interview with the RN confirmed that the resident has no foley catheter in place.

On November 14, 2014, Inspector #580 reviewed the Most Recent Full MDS for resident #40074 dated October 16, 2014, and the MDS of July 14, 2014, which indicated that a hearing aid is present and used regularly and reviewed the care plan for the communication focus which stated that the resident is hard of hearing/wears aids. On November 20, 2014 the PSW confirmed that this resident does not wear a hearing aid. On November 20, 2014, the resident confirmed that they do not wear a hearing aid.

On November 14, 2014, Inspector #580 reviewed the Most Recent Full MDS for resident #20609 dated October 31, 2014, which indicated that the resident has a hearing aid, present but not used regularly, and reviewed the care plan for the communication focus which stated that staff will ensure the hearing aid is functioning and in place. On November 20, 2014, the PSW confirmed that this resident does not wear a hearing aid.

On November 14, 2014 Inspector #580 reviewed the Most Recent Full MDS for resident #00862 dated October 7, 2014, and the MDS of June 18, 2014, which stated that the resident has a hearing aid present and used regularly. The Inspector reviewed the care plan for the communication focus which stated that the resident has a hearing aid that is used regularly. On November 20, 2014, the RPN confirmed that this resident does not wear hearing aids.

On November 14, 2014, Inspector #580 reviewed the Most Recent Full MDS for resident #80041 dated October 7, 2014, which stated the resident has no hearing aid. The Inspector reviewed the care plan for the communication focus which stated that staff will ensure the hearing aid is functioning and in place. On November 20, 2014, the RPN confirmed that this resident does not have or wear hearing aids.

Consequently, the licensee failed to ensure that there is a written plan of care for each resident that sets out clear directions to staff and others who provide direct care to the resident. [s. 6. (1) (c)]

2. On November 20, 2014 Inspector #580 reviewed the Home's Nourishment policy 05-01-28 dated August 2014, which indicated; that the dietary staff prepares any special therapeutic supplements ordered by the Registered Dietitian (RD) or Dietary Supervisor, that residents will be monitored during snacks, will be provided with personal assistance and encouragement required to safely drink, that the residents' intake is recorded; that when residents consistently refuse their snacks, especially those that have been specifically ordered, staff must communicate this information to the Dietary Supervisor and RD so that modifications/changes can be made.

On November 14, 2014, Inspector #580 reviewed the care plan for resident #00862 which indicated that the resident is to receive ½ of an Ensure in the pm (the afternoon) to be provided by dietary. Nursing staff are to wake and assist this resident to drink and that this resident is to receive a whole Ensure at hs (the evening), and that this was last reviewed by the RD on August 20, 2014, in the progress notes.

On November 19, 2014, the RD confirmed that the nutritional supplements Ensure and Boost are used interchangeably at the Home and that resident #00862 is to receive Resource 2.0 OD at the HS med pass to be given by registered staff and documented in the MAR when given. This resident is to receive ½ of an Ensure in the afternoon by dietary staff and if resident #00862 is sleeping, dietary staff are to give it to the nursing

staff who will awaken the resident and give the Ensure. This resident is also to receive a whole Ensure in the evening. On November 19, 2014, the RD confirmed that there is no documentation of Ensure or Boost being given to this resident and that the staff are not waking them if they are asleep in order to give them the Ensure or Boost as per care plan direction.

Inspector #580 reviewed the Home's Nourishment Intake Record which indicated that resident #00862's received the afternoon ½ Boost/Ensure 4/16 or 25% of the specified times and received the evening full Boost/Ensure 1/16 or 6% of the specified times.

Consequently, the licensee failed to ensure that the care set out in the plan of care was provided to the resident as specified in the plan. [s. 6. (7)]

3. On November 14, 2014, Inspector #580 spoke with the RN who confirmed that registered staff and the PSWs use the care plan for resident care information, that the care plans are located at the nursing station in a large binder and that this process is the same on each Home Area. On November 17, 2014, Inspector #543 spoke with the RAI coordinator who confirmed that all staff have access to all residents' care plan and that these care plans are located in binders on each unit. The RAI coordinator expressed concerns regarding communication amongst staff and updating care plans accordingly and that at times, care plans are updated in the computer but not on the paper care plans that are kept on the units. Therefore, errors in care provided to residents can occur.

On November 14, 2014, Inspector #580 spoke with the HCA who confirmed that staff get resident care information and direction from the care plan, from conversation with residents and from the resident's body language. In terms of communication needs for resident #00286, the HCA communicates with them face to face, but does not know what the care plan states about communication needs. On November 17, 2014, the RPN confirmed that they get care direction from the care plan. In terms of communication for resident #00286 the RPN stated that this resident is understandable, speaks and answers with yes or no, tells staff what they needs and does not wear hearing aids.

On November 14, 2014, Inspector #580 reviewed the health care record for resident #00286 including the care plan for the communication focus which stated that staff are to use non-verbal communication such as touch, facial expression, eye contact, tone of voice and posture to communicate, speak slowly using a low tone of voice, use short, direct phrases.

On November 17, 2014, Inspector #580 spoke with the RPN who confirmed that they look at the care plan for care direction, that there are no communications issues with resident #00862, that this resident speaks their mind and is clear with understanding, but the RPN was not sure of specific communication direction in the care plan and was not able to find any information in the care plan about communication, did not mention a hearing aid when asked about hearing aids for this resident. On November 17, 2014, Inspector #580 spoke with the HCA who confirmed that resident #00862 is good at communicating with staff, but was not sure what the care plan stated about communications and did not mention a hearing aid when asked about hearing aids for this resident.

Inspector #580 reviewed the health care record for resident #00862 including the care plan for the communication focus which stated that staff are to use short, direct phrases when speaking with the resident, and that they have a hearing aid that is used regularly.

On November 14, 2014, Inspector #580 spoke with the HCA who confirmed that staff get resident care information and direction from the care plan, from conversation with residents and from the resident's body language, and for communication needs for resident #20609. They confirmed the resident can converse and has no hearing aids, but does not know what the care plan states about communication needs. On November 17, 2014, the Inspector spoke with the RPN who confirmed that they get direction from the care plan, that related to focus of communication, resident #20609 is usually good to understand things but it depends on the day. When asked what the care plan specifically states regarding the communication needs of resident #20609, the RPN confirmed that they would have to look it up in the care plan, and that the resident does not wear hearing aids.

On November 14, 2014, Inspector #580 reviewed the health care records for resident #20609 including the care plan for the communication focus which stated the resident is hearing impaired in the right ear, has difficulty finding words or finishing thoughts, and staff are to use short, direct phrases when speaking with the resident, that staff are to use alternative methods of communications like the Bliss Board to communicate, encourage non-verbal language and ensure the hearing aid is functioning and in place.

On November 14, 2014, Inspector #580 spoke with the HCA who confirmed that staff get resident care direction from information posted on the walls in residents' rooms, on the resident care flow sheet, in speaking with the residents and by knowing the residents from having worked at the Home for over five years. Regarding the communication

needs for resident #40074, the HCA stated that they speak near to them, use short phrases so that the resident understands and did not mention a hearing aid when asked about hearing aids for this resident. On November 17, 2014, the Inspector spoke with the RPN who confirmed that they look at the care plan for care direction, that there are no communications issues with resident #40074, that this resident can communicate but their memory is "off", did not mention a hearing aid when asked about hearing aids for this resident and the RPN was not sure of specific communication direction in the care plan.

On November 14, 2014 Inspector #580 reviewed the health care records for resident #40074 including the care plan for the communication focus which stated that the resident is hard of hearing/wears aids, has minimal difficulty hearing when not in a quiet setting, repeats themselves/asking the same questions often and to therefore use short, direct phrases when speaking with them, to use alternative methods of communication, for example utilize a Bliss Board when communicating with the resident, that the resident has to reflect before answering, wears special apparatus to watch TV, and staff are to ensure that the hearing aid is functioning and in place.

On November 14, Inspector #580 spoke with the HCA who confirmed that staff get resident care information and direction from the care plan, from conversation with residents and from the resident's body language. In terms of resident #40186's communication needs, the HCA does not believe this resident has any communication concerns or needs, but does not know what the care plan states. On November 17, 2014, the Inspector spoke with the RPN who confirmed that they get care direction from the Care Plan, that related to focus of communication, resident #40186 speaks well, understands everything. When the HCA was asked what the care plan specifically stated regarding the communication needs of resident #40186, the RPN stated that they would have to look it up in the care plan, but this resident is not deaf or hard of hearing and does not wear hearing aids.

On November 14, 2014 Inspector #580 reviewed the health care records for resident #40186 including the care plan for the communication focus which states that the resident is usually understood, searches for words, that staff are to encourage nonverbal communication, use short, direct phrases, encourage the resident to take their time, and hold conversation in quiet areas free of distraction.

On November 17, 2014, Inspector #580 spoke with the HCA who confirmed that they get care direction from the care plan, that resident #40820 does not speak, but was not sure

what the care plan stated regarding communication needs for this resident. On November 17, 2014, the Inspector spoke with the HCA who confirmed that they get care direction from the care plan, that resident #40820 understands all, that staff explain care to the resident as they do it, but does not know what the care plan stated exactly.

Inspector #580 reviewed the health care records for resident #40820 including the care plan for the communication focus which stated that this resident no longer wears hearing aids, talks very little, is rarely or never understood and rarely or never understands, to maintain eye contact when speaking with resident, to use short, direct phrases, to use non-verbal communication such as touch, facial expression, eye contact, tone of voice and posture, to maintain a quiet, non-distracting environment, encourage the resident to take their time.

On November 17, 2014, Inspector #580 spoke with the PSW who confirmed that they get care direction from the "nursing plan book" but was not sure what care needs resident #60621 required. The Inspector spoke with another HCA who confirmed that they get care direction from the care plan but was not sure about care plan specifics for resident #60621 but confirmed that resident #60621 can tell staff what they need.

On November 14, 2014 Inspector #580 reviewed the health care records for resident #60621 including the care plan for the communication focus which stated the resident is hard of hearing when not in a quiet setting, that they are usually understood, has difficulty finding words or finishing thoughts, and that staff are to encourage non-verbal communication and use short, direct phrases.

On November 17, 2014, Inspector #580 spoke with the HCA who confirmed that they get care direction from the care plan, that resident #80041 has no issues with communication, did not mention a hearing aid when asked about hearing aids for this resident and was not sure what the care plan stated. On November 17, 2014, the HCA confirmed that they get care direction from the care plan, that resident #80041 is quiet, needs to be reminded, convinced and encouraged verbally and cared for one-on-one, did not mention a hearing aid when asked about hearing aids for this resident and was not sure what the care plan stated.

On November 14, 2014, Inspector #580 reviewed the health care records for resident #80041 including the care plan for the communication focus which stated that this resident can communicate in English and French, has episodes of disorganized speech, staff are to use short, direct phrases, and staff are to ensure the hearing aid is

functioning and in place.

On November 17, 2014, the HCA spoke with the Inspector and confirmed that they get care direction from the care plan, that resident #80274 has memory loss and needs to be reminded of things but was not sure what the care plan stated specifically. On November 17, 2014, the HCA confirmed that they get care direction from the care plan, that resident #80274 speaks and asks when they require something, but was not sure what the care plan stated specifically regarding communication.

Inspector #580 reviewed the health care records for resident #80274 the care plan for the communication focus stated that staff are to encourage nonverbal communication, use short direct phrases, encourage resident to take their time, and rely on yes and no questions.

Consequently, the licensee failed to ensure that the staff and others who provide direct care to a resident are kept aware of the contents of the resident's plan of care. [s. 6. (8)]

Additional Required Actions:

CO # - 002, 004, 005 will be served on the licensee. Refer to the "Order(s) of the Inspector".

WN #3: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 19. Duty to protect

Specifically failed to comply with the following:

s. 19. (1) Every licensee of a long-term care home shall protect residents from abuse by anyone and shall ensure that residents are not neglected by the licensee or staff. 2007, c. 8, s. 19 (1).

Findings/Faits saillants :

1. The Ministry received a Critical Incident reporting an allegation of staff to resident abuse which was inspected during the Resident Quality Inspection. Inspector #151 reviewed staff #234's personnel file and noted that documentation on file identified a history of allegations of resident abuse and neglect. The Inspector noted that despite the licensee's application of its disciplinary process and remedial interventions, the licensee

did not protect residents from abuse specifically by staff #234.

In summary of staff #234's personnel record:

1. Nov. 1, 2014 - E-mail from the RAI coordinator to the Director of Care that was then copied to the Human Resources Director. Resident #233 stated that staff member #234 had been rude and refused to help this resident with personal hygiene - RESULT: resident's care plan changed to "resident requires extensive assistance due to difficulty with mobility of upper extremities" No other information found in regards to discussion with staff #234 or actions taken.

2. November 7, 2014 - letter of discipline; refused supervisor's direction to go outside and retrieve a resident and this resulted in a three day suspension.

3. October 31, 2014 - letter of reprimand - for events occurring on August 28, 2014; staff #234 took a photograph of a resident's abdomen without permission and the resident was upset.

4. May 28, 2014- a letter stating that the Licensee denied staff' #234's request "to return to the floor that they wanted to work on and for this home area to be Staff #234's primary area of responsibility". The Licensee referenced the incident of February 2013 where Staff #234 was suspended for 3 days and excluded from working on the unit. The Licensee provided the following reasons for refusing: "residents on this floor are more vulnerable than any other areas of the Home and therefore this exclusion in your work schedule"..." even though [it has been] over one year...there have been other issues that have surfaced as well as residents refusing to have you as care giver. These incidents resulted in a further 1 day suspension in November 2013"...."you cannot accept any call-ins for this floor or perform any mutual exchanges that would require you to work on said floor."

5. Memo to Administrator by staff #230: Wednesday April 2, 2014 staff reported that a resident had stated Staff #234 had made them cry by telling them in a manner that was humiliating to them that Staff #234 would not help them and that the resident could manage on their own. When interviewed by Staff #230, and when the question of " had any staff member been mean with them, been abrupt or made them cry, the resident immediately gave Staff #234's name. The resident sitting at the table with the resident making the complaint confirmed that Staff #234 had demeaned the resident at the dinner table: [it] was said in a "tone of voice that was angry and punitive" that the resident

"should not expect that we are going to do things for them that they can do on their own". Table mate confirmed that the resident cried after the verbal exchange with Staff #234. Staff #234 was given a one day suspension.

6. Letter dated November 21, 2013 - References that Staff #234 was insubordinate to supervisor resulting in a letter of reprimand and a one day suspension. This letter directs Staff #234 to reduce hours of work to 80 hours per pay as review of their work hours showed that Staff #234 was working an average of 99 hours per pay period (2 weeks).

7. October 31, 2013-minutes of meeting with Staff #234.The licensee met with Staff #234 advising that they had: "received reports that residents do not want Staff #234 to work with them":

- resident #1 stating that Staff #234 utilized language that was bossy, loud and embarrassing;
- resident #2 stating that Staff #234 scolded the resident for ringing the bell;
- resident #3 stating that Staff #234 is always teasing and always calling the resident "mon petit" [little one];
- in addition, minutes were reflective of one incident where Staff #234 was insubordinate to a supervisor

The minutes make no mention of disciplinary action. There is a statement that Staff #234 "would try to be more professional"

8. October 27, 2013-Memo from Staff #205 to the DOC: Resident #233 was upset and did not want Staff #234 and a male PSW to provide for Resident #233's care anymore - "they tease me all the time"..."fed up". No documentation of follow up in the memo other than to suggest that the home should have a team care meeting with the resident's family.

9. October 27, 2013-Memo by Staff #205 stating that resident #237 was upset with Staff #234 because Staff #234 scolded the resident about using the call bell. Staff #234 told the resident "you ring the bell for emergencies only". The inspector found no other documentation in regards to licensee's follow-up other than a reference "to tell the resident that Staff #234's comment was inappropriate".

10. October 25, 2013-Memo by Staff #238 stating that resident #60199 cried throughout the bath stating dislike for Staff #234 because this staff member was very mean and

uses language that is bossy, loud and embarrasses the resident in front of other residents". The Inspector found no other information on the file indicating that the Licensee followed-up on the incident reported.

11. June 6, 2013- STANDARD OF CARE DISCREPANCY FORM-filed by Staff #205. The form stated that Staff #234 failed to provide nail care. The Inspector noted that the section on the form where employee's signature is required was blank. The Inspector found no further documentation that the issue was discussed with the employee and/or that the staff member refused to sign the document.

12. February 27, 2013 (3 day suspension) "witnessed to hit a resident in a chopping motion on the left upper arm. In the second instance, the staff member was seen to pull backwards on the resident's thumb". There were photos of the resident's injury, bruising to their arm, these were attached to the letter of reprimand in the staff member's file. Inspector #151 confirmed that the home did file a Critical Incident report with the Ministry regarding this matter.

13. NOTICE OF ACTION REQUIRED FORM- FEB. 14, 2013 - Staff #234 observed eating resident food in the servery area, a verbal warning was given. The form was signed by Staff #234 in acknowledgment of the verbal warning.

14. MEMO TO THE HR MANAGER FROM THE DOC DATED FEBRUARY 21, 2013- memo advises the following in relation to the resident who was alleged to have been physically abused by Staff #234 and where there was photographic evidence of resident bruising. The DOC stated the following in the memo:

-"interviewed colleagues and took notes"
-"[Staff #234] is suspended pending investigation"
-"[Staff #234] to receive 3 day suspension"
-"[Staff #234] is never to be re-assigned to a specific unit"
-"[Staff 234] is not to work more than 80 hours in any pay period"
- "repeat incident will result in termination"

15. NOTICE OF ACTION REQUIRED FORM-NOVEMBER 2, 2012 - filed by Staff #205 stating that Staff #234:
- did not provide required fluids to residents
- did not offer menu selection of hot cereal
- was argumentative with supervisor

- noting a further note "not first incident"

Inspector #151 noted that the section of this form indicating what disciplinary measure was to be taken (i.e written, suspension, etc.) was left blank and that Staff #234 did not sign this form.

16. E-MAIL FROM THE DIETARY STAFF #215 TO THE DOC DATED MAY 30, 2012- stating that Staff #234 was not following dietary procedures and was not following residents' dietary profiles in the provision of meal service and then became angry with Staff #215 for pointing it out. The RN Supervisor had to intervene. Inspector #151 found no other note in support of any follow-up.

17. NOTICE OF ACTION REQUIRED FORM: MAY 10, 2012 - Staff #234 was observed to be arguing in front of residents and discussing personal problems openly . Inspector #151 noted that the section on the form indicating what disciplinary action to be taken was blank and that the employee had not signed the form as required.

18. NOTICE OF ACTION REQUIRED FORM-APRIL 6, 2012 - Staff #234 was observed to be eating resident's food by RN. Inspector notes that the section on the form indicating what action is to be taken is blank but that Staff #234 did sign the document.

19. NOTICE OF ACTION REQUIRED FORM, SEPTEMBER 9, 2011, FILED BY THE RN-stated that Staff #234 failed to follow the resident's care plan. Staff #234 did not put the resident to bed after lunch. The care plan was explicit that because the resident had a wound, pressure relief after the meal was needed. This incident resulted in a family complaint. Inspector #151 noted that the section on the form indicating what action was taken is blank and that Staff #234 did not sign this form as per the requirement of the form. No other documentation regarding the complaint was found on the staff's file.

20. NOTICE OF ACTION REQUIRED FORM FILED, AUGUST 5, 2011, FILED BY STAFF #205-The form stated that Staff #234 did not administer the snack pass as per protocol and that snacks were left at the bedside of 5 residents. Staff #234 did this "without concern for resident safety; (i.e. choking, infection control hazard), resulting in decreased fluid intake for residents and false documentation". Inspector #151 noted that the section on the form indicating what action was taken was blank and that Staff #234 did not sign the form where indicated.

21. NOTICE OF ACTION REQUIRED FORM FILED, JULY 26, 2011, FILED BY STAFF

#205-The form stated that Staff #234 failed to provide a lotion treatment as ordered twice daily for a resident for the entire month. Inspector #151 noted that the section on the form indicating what action was to be taken was left blank and that Staff #234 did not sign the form as per the requirement of the form. No other documentation as to follow-up found on the staff member's file.

22. NOTICE OF ACTION REQUIRED FORM FILED JUNE 7, 2011 FILED BY STAFF #239 - RESIDENT COMPLAINT. The form stated that resident #40531 was upset with Staff #234 because this staff member had handled them roughly and had spoken in a loud tone of voice: "je me suis fait bardasser pas mal fort ce soir, puis je me suis fait parler fort". This resident made a statement that she did not want to get the employee in trouble or talk to the employee because they feared for their life. This resident stated further that Staff #234 did not allow them time to participate fully in their bedtime care" and "roughly pulled off their underwear and put them in their pyjamas". The note stated that Staff #234 was apprised of the complaint and in rebuttal stated: "nothing unusual occurred with resident's bedtime care, I did what I did every night, and I did nothing different tonight". Inspector #151 noted that the section on the form indicating what action was taken was left blank and that Staff #234 did not sign this form as per the requirement of the form. No other documentation found on the file in regards to this matter

23. MEMO TO THE DOC AND THE MANAGER OF HUMAN RESOURCES MARCH 9, 2011, BY STAFF #240-The memo stated that Staff #234 took a resident's call bell away because the resident was calling too many times. Removal of the call bell was witnessed by another staff member. The resident was very upset until Staff #240 returned the call bell to the resident. Staff #240 advised that there had been no time to address the issue with Staff #234 and requested the DOC or the HR Manager to follow up on it. The inspector did not find any further documentation on file in regards to this matter.

24. PROGRESS NOTE BY AN RPN DATED MARCH 16, 2011-recounts that upon arriving on the unit at 0030 h, Staff #234 advised that a resident had been ringing excessively and that the resident was yelling and quite agitated. The RPN went to the resident and the resident stated that Staff #234 took their call bell away and was none too gentle with the resident. The RPN gave the resident the call bell back. Inspector #151 did not find any further documentation on the file in regards to follow up.

25. LETTER OF DISCIPLINE DATED FEBRUARY 23, 2011, TO STAFF#234-The letter recounted that a resident experienced a responsive behaviour where the resident purposefully urinated on the floor and advised Staff #234 it was Staff #234's job to clean

it up. It was alleged that Staff #234 put the resident back in the soiled brief and laid the resident back down on the resident's heavily urine soaked bed. Staff #234 documented the following that evening: "so I put on [the] brief and sorry but layed them back on their soiled bed and pikay" [pique incontinent/positioning sheet]. The home suspended Staff #234 pending investigation and upon return to the home required Staff #234 to repeat mandatory training in regards to Gentle Persuasion Approach and U-First.

26. MEMO FROM STAFF #215 TO THE DOC DATED SEPTEMBER 10, 2010-
Staff #215 observed that Staff #234 was not following the resident's nutritional care plan by serving sugar free jam to all of the residents stating there was no time to check the dietary profiles. In addition, Staff #215 stated that Staff #234 served a resident requiring total assistance and took 15 minutes to return to assist the resident. When Staff #215 pointed out these things Staff #234 had a verbal altercation with Staff #215. Inspector #151 did not find any other documentation in regards to follow-up to the memo. In addition, Inspector noted that Staff #234's record indicated that the Licensee imposed restrictions to Staff #234's continued employment at the home.

Inspector #151 reviewed Staff #234's average hours of work per pay period for the last 3 months and noted that this employee worked an average of 105.08 hrs per pay. The Inspector audited Staff #234's assigned work location for the last 6 months and noted that Staff #234 had been assigned to one particular unit that they were not to work on 6 times.

Inspector #151 interviewed resident #40336 who informed the inspector of an incident that occurred where a PSW refused a request to assist the resident to the toilet and then to tell the resident to "jump out of bed and walk there myself". The Resident did state that they reported the incident to the RN Supervisor

The Inspector reviewed this resident's health care record and noted that the resident had a medical diagnosis that identified this resident as needing extensive assistance of 1 staff member for toileting, transferring, bathing and that resident's only way to mobilize was to use a wheelchair and self-propel. The Inspector noted that this resident was identified a high risk for falls.

The Inspector interviewed the RN Supervisor who confirmed that a report of the incident was filed and forwarded to the Director of Care on November 3, 2014.

The Inspector interviewed the Administrator and the Human Resources Manager, both of whom confirmed that they had no knowledge of the incident. The Administrator confirmed that no critical incident report was filed with the Ministry in regards to this allegation of staff to resident abuse as all of these reports go through him before being sent.

Consequently, the licensee has failed to ensure that residents were protected from abuse by anyone and free from neglect by the licensee or staff in the home. [s. 19. (1)]

Additional Required Actions:

CO # - 003 will be served on the licensee. Refer to the "Order(s) of the Inspector".

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 98. Every licensee of a long-term care home shall ensure that the appropriate police force is immediately notified of any alleged, suspected or witnessed incident of abuse or neglect of a resident that the licensee suspects may constitute a criminal offence. O. Reg. 79/10, s. 98.

Findings/Faits saillants :

1. The Ministry received a Critical Incident reporting an allegation of staff to resident abuse which was inspected during the Resident Quality Inspection. Inspector #151 reviewed staff #234's personnel file and noted that documentation on file identified a history of allegations of resident abuse and neglect. The Inspector noted that despite the licensee's application of its disciplinary process and remedial interventions, the licensee did not protect residents from abuse specifically by staff #234.

Upon review of staff #234's personnel file, inspector #155 identified that in February 2013 a three day suspension was issued to this staff member for allegations of hitting a resident in a chopping motion on the left upper arm. This staff member "was seen to pull backwards on the resident's thumb". There were photos of the resident's injury, bruising to their arm, these photos were attached to the letter of reprimand in the staff member's file. Inspector #151 confirmed that the home did file a Critical Incident report with the Ministry regarding this matter.

Inspector #543 reviewed that critical incident report and determined that the licensee did not notify the appropriate police force.

Consequently, the licensee failed to ensure that the appropriate police force was immediately notified of any alleged, suspected or witnessed incident of abuse or neglect of a resident that the licensee suspects may constitute a criminal offence. [s. 98.]

Additional Required Actions:

CO # - 006 will be served on the licensee. Refer to the "Order(s) of the Inspector".

WN #5: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 15. Accommodation services

Specifically failed to comply with the following:

s. 15. (2) Every licensee of a long-term care home shall ensure that,
(a) the home, furnishings and equipment are kept clean and sanitary; 2007, c. 8, s. 15 (2).
(b) each resident's linen and personal clothing is collected, sorted, cleaned and delivered; and 2007, c. 8, s. 15 (2).
(c) the home, furnishings and equipment are maintained in a safe condition and in a good state of repair. 2007, c. 8, s. 15 (2).

Findings/Faits saillants :

1. On November 11, 2014, Inspector #580 made an initial tour of the Home. The Inspector observed gouged dry wall, gouged baseboards, scratched railings, scratched doorways (C13, 232, 214, 215, 219-220, B15, 176, 177, 178, 183, 170), stained ceiling tiles (212, 213, A13), a bent heater (between 217-218), missing baseboards (near A41-A42); a hole in the Dining Room (112 room) separator between the dining room and theatre; and broken off dry wall corners (next to rooms 219 and 220).

On November 17, 2014, Inspector #580 observed the Second Floor Tub room and shower to have a large repaired dry wall area that was patched but not painted. On November 17, 2014, Inspector #580 inspected the Section A tub room and observed a large open area in the drywall behind the tub, approximately 2 feet wide by 6 inches high, exposing crumbled cement and an open wall.

On November 19, 2014, Inspector #151 observed that the metal door leading to a service room was heavily scored, with gouges and with large areas devoid of paint or paint flaking off to the bare metal, and that there was a large hole in the wall in corridor at baseboard level directly in front of room 321.

On November 20, 2014, Inspector #580 reviewed the May 16, 2014 minutes of the Residents' Council in which the residents request that the Home address the outdoors being dirty and neglected, the hall doors and the outside doors require painting; and the results of the 2014 resident survey stated that 3% of 23 residents found the Home interior and exterior to be mediocre.

On November 20, 2014, Inspector #580 reviewed the maintenance general audit completed February 19, 2014 which included the comments that the lounge walls need painting, the tub room walls need painting, and ceiling hallway tiles need replacing.

On November 20, 2014, inspector #580 spoke with Environmental Services staff who confirmed that the last maintenance audit was completed in February 2014 and that there is no specific plan to address painting, dry wall repairs and repairs of gouged doors and doorways, and that the repairs get planned but other concerns get in the way.

Consequently, the licensee failed to ensure that the home is maintained in a good state of repair. [s. 15. (2) (c)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that the home is maintained in a good state of repair, to be implemented voluntarily.

WN #6: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 23. Licensee must investigate, respond and act

Specifically failed to comply with the following:

s. 23. (1) Every licensee of a long-term care home shall ensure that,
(a) every alleged, suspected or witnessed incident of the following that the licensee knows of, or that is reported to the licensee, is immediately investigated:
(i) abuse of a resident by anyone,
(ii) neglect of a resident by the licensee or staff, or
(iii) anything else provided for in the regulations; 2007, c. 8, s. 23 (1).
(b) appropriate action is taken in response to every such incident; and 2007, c. 8, s. 23 (1).
(c) any requirements that are provided for in the regulations for investigating and responding as required under clauses (a) and (b) are complied with. 2007, c. 8, s. 23 (1).

Findings/Faits saillants :

1. Inspector #151 interviewed Resident #40336 who told Inspector of an incident that occurred 3 weeks ago where a PSW refused a request to assist the resident to the toilet and then to tell the resident to "jump out of bed and walk there myself". This resident confirmed that they reported the incident to the RN Supervisor

The Inspector reviewed this resident's health care record and noted this resident had a medical diagnosis that required this resident to receive extensive assistance of 1 staff member for toileting, transferring, bathing and that this resident's only way to mobilize is to use a wheelchair and self-propel. The Inspector noted that this resident was identified a high risk for falls.

The Inspector interviewed the RN Supervisor who confirmed that a report of the incident was filed and forwarded to the Director of Care on November 3, 2014.

The Inspector interviewed the Administrator and the Human Resources Manager, both of whom confirmed that they had no knowledge of the incident. The Administrator confirmed that no critical incident report was filed with the Ministry in regards to this allegation of staff to resident abuse as all of these reports go through him before being sent.

Consequently, the licensee has failed to ensure that every alleged, suspected or witnessed incident of abuse that the licensee knows of, or that is reported is immediately investigated. [s. 23. (1) (a)]

2. Inspector #151 interviewed Resident #40336 who told Inspector of an incident that occurred 3 weeks ago where a PSW refused a request to assist the resident to the toilet and then to tell the resident to "jump out of bed and walk there myself". This resident confirmed that they reported the incident to the RN Supervisor

The Inspector reviewed this resident's health care record and noted they had a medical diagnosis that required this resident to receive extensive assistance of 1 staff member for toileting, transferring, bathing and that this resident's only way to mobilize is to use a wheelchair and self-propel. The Inspector noted that this resident was identified a high risk for falls.

The Inspector interviewed the RN Supervisor who confirmed that a report of the incident was filed and forwarded to the Director of Care on November 3, 2014. The RN Supervisor stated that the Director of Care has been on holidays for the last 3 weeks.

The Inspector interviewed the Administrator and the Human Resources Manager, both of whom confirmed that they had no knowledge of the incident. The Administrator confirmed that no critical incident report was filed with the Ministry in regards to this allegation of staff to resident abuse as all of these reports go through him before being sent.

As such, the licensee failed to ensure that appropriate action is taken in response to every such incident. [s. 23. (1) (b)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that every alleged, suspected or witnessed incident of abuse that the licensee knows of, or that is reported is immediately investigated and that appropriate action is taken in response to every such incident, to be implemented voluntarily.

WN #7: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 24. Reporting certain matters to Director

Specifically failed to comply with the following:

s. 24. (1) A person who has reasonable grounds to suspect that any of the following has occurred or may occur shall immediately report the suspicion and the information upon which it is based to the Director:
1. Improper or incompetent treatment or care of a resident that resulted in harm or a risk of harm to the resident. 2007, c. 8, s. 24 (1), 195 (2).
2. Abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or a risk of harm to the resident. 2007, c. 8, s. 24 (1), 195 (2).
3. Unlawful conduct that resulted in harm or a risk of harm to a resident. 2007, c. 8, s. 24 (1), 195 (2).
4. Misuse or misappropriation of a resident's money. 2007, c. 8, s. 24 (1), 195 (2).
5. Misuse or misappropriation of funding provided to a licensee under this Act or the Local Health System Integration Act, 2006. 2007, c. 8, s. 24 (1), 195 (2).

Findings/Faits saillants :

1. Inspector #151 interviewed Resident #40336 who told Inspector of an incident that occurred 3 weeks ago where a PSW refused a request to assist the resident to the toilet and then to tell the resident to "jump out of bed and walk there myself". This resident confirmed that they reported the incident to the RN Supervisor.

The Inspector reviewed this resident's health care record and noted they had a medical diagnosis that required this resident receive extensive assistance of 1 staff member for toileting, transferring, bathing and that this resident's only way to mobilize is to use a wheelchair and self-propel. The Inspector noted that this resident was identified a high risk for falls.

The Inspector interviewed the RN Supervisor who confirmed that a report of the incident was filed and forwarded to the Director of Care on November 3, 2014. The RN Supervisor stated that the Director of Care has been on holidays for the last 3 weeks.

The Inspector interviewed the Administrator and the Human Resources Manager, both of whom confirmed that they had no knowledge of the incident. The Administrator confirmed that no critical incident report was filed with the Ministry in regards to this allegation of staff to resident abuse as all of these reports go through him before being sent.

As such, the licensee has failed to ensure that the person who had reasonable grounds to suspect that any of the following has occurred or may occur, immediately reported the suspicion and the information upon which it was based to the Director
1. Improper or incompetent treatment of care of a resident that resulted in harm or a risk of harm.
2. Abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or risk of harm. [s. 24. (1)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that the person who has reasonable grounds to suspect that improper or incompetent treatment or care of a resident that resulted in risk of harm immediately reports the suspicion and the information upon which it is based to the Director., to be implemented voluntarily.

WN #8: The Licensee has failed to comply with O.Reg 79/10, s. 35. Foot care and nail care

Specifically failed to comply with the following:

s. 35. (2) Every licensee of a long-term care home shall ensure that each resident of the home receives fingernail care, including the cutting of fingernails. O. Reg. 79/10, s. 35 (2).

Findings/Faits saillants :

1. On November 19, 2014, Inspector #580 spoke with the two RNs working dayshift, as well as the RN covering for evening all of whom confirmed:

-that each of the home's residents has a labelled nail clipper in an individual labelled container in the resident's home area tub room;
-that during baths, nail care is included and comprises of the cleaning and cutting of nails using the resident's individually labelled nail clipper which is kept in the resident's home area tub room;
-that staff doing bath care report nail care not done to the registered staff;
-that staff doing bath care report missing nail clippers to the registered staff and that new nail clippers are supplied from the home's nail clipper supply; and
-that staff do not use the same nail clipper on more than one resident.

On November 19, 2014, Inspector #580 reviewed the Home's Bathing policy B-005 dated August 2007 which states that nail care is to be done with each type of bath.

On November 18, 2014 Inspector #580 observed the Home's bath schedule for the first

floor and noted that resident #40186 was scheduled for baths on Tuesday. On November 18, 2014, Inspector #580 spoke with resident #40186 who confirmed that they did not wish their fingernails cut as they were growing them out for Christmas, that their toenails were not cut, and that when staff cut their nails they use their nail clippers in the tub room. On November 18, 2014, Inspector #580 spoke with the PSW who confirmed that they did not feel comfortable cutting residents' nails, that they did not report this to the registered staff and confirmed that they did bathe resident #40186 that evening. On November 17 and 18, 2014, Inspector #580 found the tub room's nail clipper container labelled #40186 to be empty, found no nail clippers in this resident's bedside or bathroom drawers. On November 18, 2014, the PSW confirmed that they did not cut the nails of residents who seem agitated and only sometimes reports this to the registered staff in charge.

On November 18, 2014, Inspector #580 observed the home's bath schedule for the first floor and noted that resident #20609's scheduled bath day was Tuesday. On November 18, 2014, inspector #580 spoke with resident #20609 who confirmed that they had had a bath, but they did not cut their nails although their toe nails really needed to be cut, and that their nail clippers are kept in the tub room. On November 18, 2014, Inspector #580 spoke with the PSW who confirmed that they did not feel comfortable cutting finger nails, that they did not report this to the registered staff, and confirmed that they bathed resident #20609 that evening. On November 17 and 18, 2014 Inspector #580 found the tub room's nail clipper container labelled #20609 to be empty, found no nail clippers in the resident's bedside or bathroom drawers. On November 19, 2014, Inspector #580 reviewed resident #20609's Resident Flow Sheet for November 2014 (from November 7 – 18) which indicated that this resident received baths on November 8 and 14, 2014.

On November 18, 2014, Inspector #580 observed resident #00286's fingernails to be long but clean. On November 19, 2014, Inspector #580 reviewed resident #00286's Resident Flow Sheet for November 2014 which indicated that the resident received baths on November 6, 9 and 16, 2014. On November 17 and 18, 2014, Inspector #580 observed the tub room's nail clipper container labelled #00286 to be empty, and found no nail clippers in the resident's bedside or bathroom drawers.

On November 19, 2014, Inspector #580 reviewed resident #221's Resident Flow Sheet for November 2014 which indicated that this resident received a bath on November 2, 4, 13, 15, and 19, 2014. On November 19, 2014, Inspector #580 observed resident #221's fingernails to be long, dirty and both little finger nails to be jagged. On November 19, 2014, Inspector #580 spoke with the RPN who agreed that this resident's fingernails

were not clean, jagged and long. On November 19, 2014, the RPN confirmed that they had given a bath and cut the nails of resident #221. On November 19, 2014, the RPN confirmed that the tub room's nail clipper container labelled resident #221 was empty and that they probably did not cut resident #221's nails after having initially stated that they had and had signed confirming that they had given resident #221 a bath.

On November 19, 2014 Inspector #580 reviewed resident #206's Resident Flow Sheet for November 2014 which indicated the resident received a bath on November 3, 9, 13, and 16, 2014. On November 19, 2014, Inspector #580 spoke with the RPN who confirmed that resident #206's nails were long and not recently cut. On November 19, 2014, Inspector #580 spoke with the RPN who confirmed that they had given a bath and cut the nails of resident #229. On November 19, 2014 Inspector #580 observed that this resident's nails were long. On November 19, 2014, Inspector #580 spoke with the RPN who confirmed that the tub room's nail clipper container for resident #229 was empty and that they probably did not cut the resident's nails after having initially stated that they had and had signed confirming that they had given this resident their bath. On November 19, 2014, Inspector #580 reviewed resident #229's Resident Flow Sheet for November 2014 which indicated that this resident received only partials baths in November, 2014.

Consequently, the licensee failed to ensure that each resident of the home received fingernail care, including the cutting of fingernails. [s. 35. (2)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that each resident of the home receives fingernail care, which includes the cutting of fingernails, to be implemented voluntarily.

WN #9: The Licensee has failed to comply with O.Reg 79/10, s. 37. Personal items and personal aids

Specifically failed to comply with the following:

s. 37. (1) Every licensee of a long-term care home shall ensure that each resident of the home has his or her personal items, including personal aids such as dentures, glasses and hearing aids,
(a) labelled within 48 hours of admission and of acquiring, in the case of new items; and O. Reg. 79/10, s. 37 (1).
(b) cleaned as required. O. Reg. 79/10, s. 37 (1).

Findings/Faits saillants :

1. On November 17, 2014, Inspector #580 observed the First Floor Tub room and shower to have 1 opened unlabelled and used jar of petroleum jelly and 1 unlabelled open and used jar of Infazinc. On November 17, 2014 Inspector #580 observed the Second Floor Tub room and shower to have 1 unlabelled, used and almost empty jar of petroleum jelly, 3 unlabelled and used jar of Infazinc and 1 unlabelled and unwrapped bar of soap.

On November 17, 2014, Inspector #580 spoke with the RPN who confirmed that they did not give out nail clippers to staff doing nail care, and does not know what to do regarding the lack of individual nail clippers. This RPN had provided nail care to a resident during a bath and could not find that resident's nail clippers and therefore did not provide nail care, stated that many of the individually labelled nail clipper drawers need to be updated as the residents have been discharged and do not reflect the present resident population.

On November 17, 2014, Inspector #580 spoke with the PSW who confirmed that most residents do not have individual nail clippers for use in the tub room, that they never use the same nail clippers on several residents, but could not confirm what they did with the lack of individually labelled nail clippers, or where they got a new supply, or how they performed nail care on residents.

Consequently, the licensee failed to ensure that each resident of the home has his or her personal items, specifically nail clippers, toe-nail clippers, jars of Infazinc or petroleum jelly, and or soap bars labelled within 48 hours of admission and of acquiring, in the case of new items. [s. 37. (1) (a)]

WN #10: The Licensee has failed to comply with O.Reg 79/10, s. 129. Safe storage of drugs

Specifically failed to comply with the following:

s. 129. (1) Every licensee of a long-term care home shall ensure that,
(a) drugs are stored in an area or a medication cart,
(i) that is used exclusively for drugs and drug-related supplies,
(ii) that is secure and locked,
(iii) that protects the drugs from heat, light, humidity or other environmental conditions in order to maintain efficacy, and
(iv) that complies with manufacturer's instructions for the storage of the drugs; and O. Reg. 79/10, s. 129 (1).
(b) controlled substances are stored in a separate, double-locked stationary cupboard in the locked area or stored in a separate locked area within the locked medication cart. O. Reg. 79/10, s. 129 (1).

Findings/Faits saillants :

1. On November 17, 2014, Inspector #151 observed 2 trays of prescribed topical medications sitting on an open desk at the nursing station and that these medications were not in any registered staff's view. Inspector #151 observed that a resident used the desk area where these medications were found as a short-cut from one corridor to the other. This resident had easy access to the medications. Inspector interviewed the RPN who stated that the medications should not have been there, confirmed that it was their responsibility to lock these medications in the medication room as per the home's policy.

Consequently, the licensee has failed to ensure that drugs are stored in an area or a medication cart that is secure and locked. [s. 129. (1) (a)]

Issued on this 24th day of February, 2015

Signature of Inspector(s)/Signature de l’inspecteur ou des inspecteurs

Original report signed by the inspector.

Ontario

Ministry of Health and Long-Term Care

Order(s) of the Inspector
Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007,* S.O. 2007, c.8

Ministére de la Santé et des Soins de longue durée

Ordre(s) de l'inspecteur
Aux termes de l'article 153 et/ou de l'article 154 *de la Loi de 2007 sur les foyers de soins de* longue durée, L.O. 2007, chap. 8

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

Division de la responsabilisation et de la performance du système de santé
Direction de l'amélioration de la performance et de la conformité

Public Copy/Copie du public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	TIFFANY BOUCHER (543), MONIQUE BERGER (151), VALA MONESTIMEBELTER (580)
Inspection No. / No de l'inspection :	2014_282543_0027
Log No. / Registre no:	S-000478-14
Type of Inspection / Genre d'inspection:	Resident Quality Inspection
Report Date(s) / Date(s) du Rapport :	Feb 19, 2015
Licensee / Titulaire de permis :	THE BOARD OF MANAGEMENT OF THE DISTRICT OF NIPISSING WEST 100 Michaud Street, STURGEON FALLS, ON, P2B-2Z4
LTC Home / Foyer de SLD :	AU CHATEAU 100 MICHAUD STREET, STURGEON FALLS, ON, P2B-2Z4
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	JACQUES DUPUIS

Ontario

Ministry of Health and Long-Term Care

Order(s) of the Inspector
Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007,* S.O. 2007, c.8

Ministére de la Santé et des Soins de longue durée

Ordre(s) de l'inspecteur
Aux termes de l'article 153 et/ou de l'article 154 *de la Loi de 2007 sur les foyers de soins de* longue durée, L.O. 2007, chap. 8

To THE BOARD OF MANAGEMENT OF THE DISTRICT OF NIPISSING WEST, you are hereby required to comply with the following order(s) by the date(s) set out below:

Order # / Ordre no : 001

Order Type / Genre d'ordre : Compliance Orders, s. 153. (1) (a)

Pursuant to / Aux termes de :

LTCHA, 2007 S.O. 2007, c.8, s. 3. (1) Every licensee of a long-term care home shall ensure that the following rights of residents are fully respected and promoted:

1. Every resident has the right to be treated with courtesy and respect and in a way that fully recognizes the resident's individuality and respects the resident's dignity.
2. Every resident has the right to be protected from abuse.
3. Every resident has the right not to be neglected by the licensee or staff.
4. Every resident has the right to be properly sheltered, fed, clothed, groomed and cared for in a manner consistent with his or her needs.
5. Every resident has the right to live in a safe and clean environment.
6. Every resident has the right to exercise the rights of a citizen.
7. Every resident has the right to be told who is responsible for and who is providing the resident's direct care.
8. Every resident has the right to be afforded privacy in treatment and in caring for his or her personal needs.
9. Every resident has the right to have his or her participation in decision-making respected.
10. Every resident has the right to keep and display personal possessions, pictures and furnishings in his or her room subject to safety requirements and the rights of other residents.
11. Every resident has the right to,

i. participate fully in the development, implementation, review and revision of his or her plan of care,

ii. give or refuse consent to any treatment, care or services for which his or her consent is required by law and to be informed of the consequences of giving or refusing consent,

iii. participate fully in making any decision concerning any aspect of his or her care, including any decision concerning his or her admission, discharge or transfer to or from a long-term care home or a secure unit and to obtain an independent opinion with regard to any of those matters, and

iv. have his or her personal health information within the meaning of the Personal

Health Information Protection Act, 2004 kept confidential in accordance with that Act, and to have access to his or her records of personal health information, including his or her plan of care, in accordance with that Act.

12. Every resident has the right to receive care and assistance towards independence based on a restorative care philosophy to maximize independence to the greatest extent possible.

13. Every resident has the right not to be restrained, except in the limited circumstances provided for under this Act and subject to the requirements provided for under this Act.

14. Every resident has the right to communicate in confidence, receive visitors of his or her choice and consult in private with any person without interference.

15. Every resident who is dying or who is very ill has the right to have family and friends present 24 hours per day.

16. Every resident has the right to designate a person to receive information concerning any transfer or any hospitalization of the resident and to have that person receive that information immediately.

17. Every resident has the right to raise concerns or recommend changes in policies and services on behalf of himself or herself or others to the following persons and organizations without interference and without fear of coercion, discrimination or reprisal, whether directed at the resident or anyone else,

i. the Residents' Council,

ii. the Family Council,

iii. the licensee, and, if the licensee is a corporation, the directors and officers of the corporation, and, in the case of a home approved under Part VIII, a member of the committee of management for the home under section 132 or of the board of management for the home under section 125 or 129,

iv. staff members,

v. government officials,

vi. any other person inside or outside the long-term care home.

18. Every resident has the right to form friendships and relationships and to participate in the life of the long-term care home.

19. Every resident has the right to have his or her lifestyle and choices respected.

20. Every resident has the right to participate in the Residents' Council.

21. Every resident has the right to meet privately with his or her spouse or another person in a room that assures privacy.

22. Every resident has the right to share a room with another resident according to their mutual wishes, if appropriate accommodation is available.

23. Every resident has the right to pursue social, cultural, religious, spiritual and

other interests, to develop his or her potential and to be given reasonable assistance by the licensee to pursue these interests and to develop his or her potential.

24. Every resident has the right to be informed in writing of any law, rule or policy affecting services provided to the resident and of the procedures for initiating complaints.

25. Every resident has the right to manage his or her own financial affairs unless the resident lacks the legal capacity to do so.

26. Every resident has the right to be given access to protected outdoor areas in order to enjoy outdoor activity unless the physical setting makes this impossible.

27. Every resident has the right to have any friend, family member, or other person of importance to the resident attend any meeting with the licensee or the staff of the home. 2007, c. 8, s. 3 (1).

Order / Ordre :

The licensee shall prepare, submit and implement a plan for achieving compliance to ensure that the following rights of residents are fully respected and promoted:

-that every resident in the home is treated with courtesy and respect and in a way that fully recognizes the residents' dignity with respect to where Physician examinations are performed and storing of equipment in residents' rooms; and

-that every resident in the home is afforded privacy in treatment and in caring for his/her personal needs with respect to administering treatments; and

-that every resident is afforded privacy in caring for their personal needs in relation to the use of baby monitors and the home's call bell system for eavesdropping purposes

This plan shall be submitted in writing to Tiffany Boucher, Long Term Care Homes Nursing Inspector, Ministry of Health and Long Term Care, Performance Improvement and Compliance Branch, 159 Cedar Street, Suite 403, Sudbury, Ontario, P3E 6A5, or Fax at 705 564-3133 or email tiffany.boucher@ontario.ca . This plan must be submitted by March 2, 2015.

Grounds / Motifs :

1. On November 13, 2014, inspector #151 observed staff storing resident equipment such as a resident lift and commode in a resident's room,

encroaching on resident's space. The inspector asked the PSW why the lift and commode were in the resident's room who stated "because we have no other area to store this equipment".

Consequently, the licensee failed to ensure that the resident was treated with courtesy and respect and in a way that fully recognizes the resident's individuality and respects the resident's dignity.
(151)

2. On November 12, 2014, Inspector #543 observed the RPN administering an Insulin injection to a resident in the dining room. The RPN lifted the resident's shirt, exposing the resident's abdomen. Other residents were observed in the dining room at that time.

Inspector #543 was approached by the Administrator regarding the above incident and stated that all RPNs had been notified in the past, that under no circumstances would they administer any injections/treatments in the dining room. The Administrator confirmed that the practice of administering treatments in the dining room is cause for disciplinary action.

On November 18, 2014, Inspector #151 observed medication administration on one of the units of the home. The inspector observed that resident #212 was asked by the RPN to come to the empty living room in order to give them their morning Insulin in private. This resident had been seated with other residents in the hallway by the elevator. This resident protested having to move as it was not something they usually asked of them. Inspector #151 asked this resident where staff typically administer their Insulin injections. The resident responded that the staff will give the Insulin wherever they found them, in their room, in the lounge or in the dining room.

On November 13, 2014, Inspector #151 observed that the home's physician was making rounds on one of the units. The inspector observed the following; the physician listened to a resident's chest (which involved lifting the resident's shirt) at the nursing station. Also in the area were the Inspector, the RN, the physician's aide, and 5 residents sitting in chairs at the desk. The physician went to a resident sitting in one of the chairs around the nursing station and with the help of the home's physician aide, lifted the resident's shirt up to their neck to visualize the resident's back.

The above incidents were reported to the Administrator who stated that he also saw this as inappropriate and added that the home provides the physician with a special room for this or the physician could have examined the residents in their rooms. The Administrator stated that he would be speaking to the physician.

On November 13, 2014, Inspector #151 was seated at the nursing desk on the unit for approximately 3 hours reviewing health care records. The Inspector noted that two baby monitor receivers were at the desk and that they were in the "on" position. The Inspector was able to hear what was said in resident to staff and resident to visitor exchanges and was able to hear the residents move about in their rooms.

Inspector #151 asked the RN why the monitors were needed. The RN stated that one resident has frequent falls and the monitor alerts staff as to when the resident is moving about their room. A bed and chair alarm was tried but the resident kept pulling it off.

Another resident frequently wanders, the monitor allows staff to hear when this resident leaves the room.

The receiver for the monitor is located on an open shelf that adjoins and is open to the dining room, small living room and both corridors. It is not even in the privacy of the nursing station. All staff, residents and visitors in the hallways, lounge or dining room can overhear what is being received.

A discussion ensued as to the residents' right to privacy and that this included acoustic privacy. Inspector #151 spoke with the RN who confirmed that all the call bell systems on every resident unit had the ability to eavesdrop on residents but stated that the intent of eavesdropping was to hear the resident when they got up and to prevent falls and wandering.

The Inspector spoke to the Administrator, who understood the privacy issues related to the baby monitors. The issue with the call bells is the same issue, that of resident privacy.

The Inspector spoke to the Infection Control Nurse in charge who stated that they had good intentions but now sees how it transgresses the resident's right to privacy. The Infection Control Nurse intends to ask other homes how they monitor residents who wander or who are at risk for falls.

On November 14, 2014, the RN came to debate the baby monitor issue with Inspector #151 and advised that the building's entire call bell system has the ability to listen in on what was is going on in the rooms and that it was turned on especially on nights.

Consequently, the licensee failed to ensure that the resident had the right to be afforded privacy in treatment and in caring for his or her personal needs. (543)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Mar 13, 2015

Order # / Ordre no : 002

Order Type / Genre d'ordre : Compliance Orders, s. 153. (1) (a)

Pursuant to / Aux termes de :

LTCHA, 2007 S.O. 2007, c.8, s. 6. (1) Every licensee of a long-term care home shall ensure that there is a written plan of care for each resident that sets out,
(a) the planned care for the resident;
(b) the goals the care is intended to achieve; and
(c) clear directions to staff and others who provide direct care to the resident. 2007, c. 8, s. 6 (1).

Order / Ordre :

The licensee shall ensure:

-that residents #60621, #40708, #40186, #40820, #60199, #20609, #00862, #80041 and all residents have a plan of care which provides clear direction to staff and others who provide direct care

Grounds / Motifs :

1. Inspector observed resident #60621 seated in their wheelchair with a lap-belt in place. The inspector reviewed resident's care plan in regards to restraints/PASD which only identified the use of a table-top. This care plan identified that the table-top is used for the resident's need to control poor posture. The PASD-table-top is to be untied on wheelchair for meals only and that staff are to check on this resident hourly and release the PASD to reposition every 2 hours and as required. There is no mention of lap-belt in this resident's care plan.

Inspector #543 spoke with the RN Supervisor regarding this resident's care plan not addressing the use of a lap-belt, who confirmed that the care plan should have identified this resident's need for a lap-belt.

Consequently the licensee failed to ensure that the plan of care set out clear direction to staff and others who provide direct care to the resident.

Inspector #151 reviewed resident health care records. The inspector noted that

several care plans did not provide clear direction to staff providing care:

Resident #60621: identified in the current plan of care that the resident required a pureed diet related to risk of choking and that resident pockets "chunks" of food and will eventually spit the food out. In the section that identified 'prevent/minimize choking" as the goal, the intervention stated: "Offer cheese and crackers for pm snack". The inspector interviewed the Dietitian who confirmed that the offer of cheese and crackers has been outdated for some time.

Resident #40708: the plan of care identified that a resident has the following intervention: "foley catheter in place to promote healing and keep them dry". An inspector observation and an interview with the RN confirmed that the resident has no foley catheter in place.

Resident #40186: the plan of care identified that a resident has the following intervention: "foley catheter in place to promote healing and keep them dry". An inspector observation and an interview with the RN confirmed that the resident has no foley catheter in place.

Resident #40820: the plan of care identified that a resident has the following intervention: "foley catheter in place to promote healing and keep them dry". An inspector observation and an interview with the RN confirmed that the resident has no foley catheter in place.

Resident #60199: the plan of care identifies that aresident has the following intervention: "foley catheter in place to promote healing and keep them dry". An inspector observation and an interview with the RN confirmed that the resident has no foley catheter in place.

On November 14, 2014, inspector #580 reviewed the Most Recent Full MDS assessment for resident #40074 dated October 16, 2014, and the MDS of July 14, 2014, which indicated that a hearing aid is present and used regularly; and reviewed the care plan for the communication focus which stated that the resident is hard of hearing/wears aids. On November 20, 2014 the PSW confirmed that this resident does not wear a hearing aid. On November 20, 2014, the resident confirmed that they do not wear a hearing aid.

On November 14, 2014, inspector #580 reviewed the Most Recent Full MDS

assessment for resident #20609 dated October 31, 2014, which indicated that the resident has a hearing aid, present but not used regularly, and reviewed the care plan for the communication focus which stated that staff will ensure the hearing aid is functioning and in place. On November 20, 2014, the PSW confirmed that this resident does not wear a hearing aid.

On November 14, 2014 Inspector #580 reviewed the Most Recent Full MDS assessment for resident #00862 dated October 7, 2014, and the MDS of June 18, 2014, which stated that the resident has a hearing aid present and used regularly. The inspector reviewed the care plan for the communication focus which stated that the resident has a hearing aid that is used regularly. On November 20, 2014, the RPN confirmed that this resident does not wear hearing aids.

On November 14, 2014, Inspector #580 reviewed the Most Recent Full MDS assessment for resident #80041 dated October 7, 2014, which stated the resident has no hearing aid. The inspector reviewed the care plan for the communication focus which stated that staff will ensure the hearing aid is functioning and in place. On November 20, 2014, the RPN confirmed that this resident does not have or wear hearing aids.

Consequently, the licensee failed to ensure that there is a written plan of care for each resident that sets out clear directions to staff and others who provide direct care to the resident.
(151)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Mar 13, 2015

Ontario

Ministry of Health and Long-Term Care

Order(s) of the Inspector
Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007,* S.O. 2007, c.8

Ministére de la Santé et des Soins de longue durée

Ordre(s) de l'inspecteur
Aux termes de l'article 153 et/ou de l'article 154 *de la Loi de 2007 sur les foyers de soins de* longue durée, L.O. 2007, chap. 8

Order # / Ordre no : 003

Order Type / Genre d'ordre : Compliance Orders, s. 153. (1) (a)

Pursuant to / Aux termes de :

LTCHA, 2007 S.O. 2007, c.8, s. 19. (1) Every licensee of a long-term care home shall protect residents from abuse by anyone and shall ensure that residents are not neglected by the licensee or staff. 2007, c. 8, s. 19 (1).

Order / Ordre :

To achieve compliance with the duty to protect all residents from abuse and/or neglect by the licensee or staff, the licensee shall prepare, submit and implement a plan for achieving compliance to ensure:

-that the licensee protects residents from abuse by anyone and ensures that residents are not neglected by the licensee or staff

-that staff member #234 is afforded no opportunity to further abuse and/or neglect residents of the home; and

-that any form of abuse and/or neglect of residents, specifically with respect to staff #234 ceases immediately; and

-that the licensee's application of its disciplinary process and corrective interventions are effective in the prevention of abuse and/or neglect towards residents in the home.

This plan shall be submitted in writing to Tiffany Boucher, Long Term Care Homes Inspector, Ministry of Health and Long Term Care, Performance Improvement and Compliance Branch, 159 Cedar Street, Suite 403, Sudbury, Ontario, P3E 6A5, or Fax at 705 564-3133 or email tiffany.boucher@ontario.ca . This plan must be submitted by March 2, 2015.

Grounds / Motifs :

1. The Ministry received a Critical Incident reporting an allegation of staff to resident abuse which was inspected during the Resident Quality Inspection. Inspector #151 reviewed staff #234's personnel file and noted that

documentation on file identified a history of allegations of resident abuse and neglect. The Inspector noted that despite the licensee's application of its disciplinary process and remedial interventions, the licensee did not protect residents from abuse specifically by staff #234.

In summary of staff #234's personnel record:

1. Nov. 1, 2014 - E-mail from the RAI coordinator to the Director of Care that was then copied to the Human Resources Director. Resident #233 stated that staff member #234 had been rude and refused to help this resident with personal hygiene - RESULT: resident's care plan changed to "resident requires extensive assistance due to difficulty with mobility of upper extremities" No other information found in regards to discussion with staff #234 or actions taken.

2. November 7, 2014 - letter of discipline; refused supervisor's direction to go outside and retrieve a resident and this resulted in a three day suspension.

3. October 31, 2014 - letter of reprimand - for events occurring on August 28, 2014; staff #234 took a photograph of a resident's abdomen without permission and the resident was upset.

4. May 28, 2014- a letter stating that the Licensee denied staff' #234's request "to return to the unit that they wanted to work on and for this home area to be Staff #234's primary area of responsibility". The Licensee referenced the incident of February 2013 where Staff #234 was suspended for 3 days and excluded from working on the unit. The Licensee provided the following reasons for refusing: "residents on this floor are more vulnerable than any other areas of the Home and therefore this exclusion in your work schedule"..." even though [it has been] over one year...there have been other issues that have surfaced as well as residents refusing to have you as care giver. These incidents resulted in a further 1 day suspension in November 2013"...."you cannot accept any call-ins for this floor or perform any mutual exchanges that would require you to work on said floor."

5. Memo to Administrator by staff #230: Wednesday April 2, 2014 staff reported that a resident had stated Staff #234 had made them cry by telling them in a manner that was humiliating to them that Staff #234 would not help them and that the resident could manage on their own. When interviewed by Staff #230, and when the question of " had any staff member been mean with them, been

abrupt or made them cry, the resident immediately gave Staff #234's name. The resident sitting at the table with the resident making the complaint confirmed that Staff #234 had demeaned the resident at the dinner table: [it] was said in a "tone of voice that was angry and punitive" that the resident "should not expect that we are going to do things for them that they can do on their own". Table mate confirmed that the resident cried after the verbal exchange with Staff #234. Staff #234 was given a one day suspension.

6. Letter dated November 21, 2013 - References that Staff #234 was insubordinate to supervisor resulting in a letter of reprimand and a one day suspension. This letter directs Staff #234 to reduce hours of work to 80 hours per pay as review of their work hours showed that Staff #234 was working an average of 99 hours per pay period (2 weeks).

7. October 31, 2013-minutes of meeting with Staff #234.The licensee met with Staff #234 advising that they had: "received reports that residents do not want Staff #234 to work with them":

- resident #1 stating that Staff #234 utilized language that was bossy, loud and embarrassing;
- resident #2 stating that Staff #234 scolded the resident for ringing the bell;
- resident #3 stating that Staff #234 is always teasing and always calling the resident "mon petit" [little one];
- in addition, minutes were reflective of one incident where Staff #234 was insubordinate to a supervisor

The minutes make no mention of disciplinary action. There is a statement that Staff #234 "would try to be more professional"

8. October 27, 2013-Memo from Staff #205 to the DOC: Resident #233 was upset and did not want Staff #234 and a male PSW to provide for Resident #233's care anymore - "they tease me all the time"..."fed up". No documentation of follow up in the memo other than to suggest that the home should have a team care meeting with the resident's family.

9. October 27, 2013-Memo by Staff #205 stating that resident #237 was upset with Staff #234 because Staff #234 scolded the resident about using the call bell. Staff #234 told the resident "you ring the bell for emergencies only". The inspector found no other documentation in regards to licensee's follow-up other

than a reference "to tell the resident that Staff #234's comment was inappropriate".

10. October 25, 2013-Memo by Staff #238 stating that resident #60199 cried throughout the bath stating dislike for Staff #234 because this staff member was very mean and uses language that is bossy, loud and embarrasses the resident in front of other residents". The Inspector found no other information on the file indicating that the Licensee followed-up on the incident reported.

11. June 6, 2013- STANDARD OF CARE DISCREPANCY FORM-filed by Staff #205. The form stated that Staff #234 failed to provide nail care. The Inspector noted that the section on the form where employee's signature is required was blank. The Inspector found no further documentation that the issue was discussed with the employee and/or that the staff member refused to sign the document.

12. February 27, 2013 (3 day suspension) "witnessed to hit a resident in a chopping motion on the left upper arm. In the second instance, the staff member was seen to pull backwards on the resident's thumb". There were photos of the resident's injury, bruising to their arm, these were attached to the letter of reprimand in the staff member's file. Inspector #151 confirmed that the home did file a Critical Incident report with the Ministry regarding this matter.

13. NOTICE OF ACTION REQUIRED FORM- FEB. 14, 2013 - Staff #234 observed eating resident food in the servery area, a verbal warning was given. The form was signed by Staff #234 in acknowledgment of the verbal warning.

14. MEMO TO THE HR MANAGER FROM THE DOC DATED FEBRUARY 21, 2013- memo advises the following in relation to the resident who was alleged to have been physically abused by Staff #234 and where there was photographic evidence of resident bruising. The DOC stated the following in the memo:

-"interviewed colleagues and took notes"
-"[Staff #234] is suspended pending investigation"
-"[Staff #234] to receive 3 day suspension"
-“[Staff #234] is never to be re-assigned to a specific unit"
-"[Staff 234] is not to work more than 80 hours in any pay period"
- "repeat incident will result in termination"

15. NOTICE OF ACTION REQUIRED FORM-NOVEMBER 2, 2012 - filed by Staff #205 stating that Staff #234:
- did not provide required fluids to residents
- did not offer menu selection of hot cereal
- was argumentative with supervisor
- noting a further note "not first incident"

Inspector #151 noted that the section of this form indicating what disciplinary measure was to be taken (i.e written, suspension, etc.) was left blank and that Staff #234 did not sign this form.

16. E-MAIL FROM THE DIETARY STAFF #215 TO THE DOC DATED MAY 30, 2012- stating that Staff #234 was not following dietary procedures and was not following residents' dietary profiles in the provision of meal service and then became angry with Staff #215 for pointing it out. The RN Supervisor had to intervene. Inspector #151 found no other note in support of any follow-up.

17. NOTICE OF ACTION REQUIRED FORM: MAY 10, 2012 - Staff #234 was observed to be arguing in front of residents and discussing personal problems openly . Inspector #151noted that the section on the form indicating what disciplinary action to be taken was blank and that the employee had not signed the form as required.

18. NOTICE OF ACTION REQUIRED FORM-APRIL 6, 2012 - Staff #234 was observed to be eating resident's food by RN. Inspector notes that the section on the form indicating what action is to be taken is blank but that Staff #234 did sign the document.

19. NOTICE OF ACTION REQUIRED FORM, SEPTEMBER 9, 2011, FILED BY THE RN-stated that Staff #234 failed to follow the resident's care plan. Staff #234 did not put the resident to bed after lunch. The care plan was explicit that because the resident had a wound and that pressure relief after the meal was needed. This incident resulted in a family complaint. Inspector #151 noted that the section on the form indicating what action was taken is blank and that Staff #234 did not sign this form as per the requirement of the form. No other documentation regarding the complaint was found on the staff's file.

20. NOTICE OF ACTION REQUIRED FORM FILED, AUGUST 5, 2011, FILED BY STAFF #205-The form stated that Staff #234 did not administer the snack

pass as per protocol and that snacks were left at the bedside of 5 residents. Staff #234 did this "without concern for resident safety; (i.e. choking, infection control hazard), resulting in decreased fluid intake for residents and false documentation". Inspector #151 noted that the section on the form indicating what action was taken was blank and that Staff #234 did not sign the form where indicated.

21. NOTICE OF ACTION REQUIRED FORM FILED, JULY 26, 2011, FILED BY STAFF #205-The form stated that Staff #234 failed to provide a lotion treatment as ordered twice daily for a resident for the entire month. Inspector #151 noted that the section on the form indicating what action was to be taken was left blank and that Staff #234 did not sign the form as per the requirement of the form. No other documentation as to follow-up found on the staff member's file.

22. NOTICE OF ACTION REQUIRED FORM FILED JUNE 7, 2011 FILED BY STAFF #239 - RESIDENT COMPLAINT. The form stated that resident #40531 was upset with Staff #234 because this staff member had handled them roughly and had spoken in a loud tone of voice: "je me suis fait bardasser pas mal fort ce soir, puis je me suis fait parler fort". This resident made a statement that they did not want to get the employee in trouble or talk to the employee because they feared for their life. This resident stated further that Staff #234 did not allow them time to participate fully in their bedtime care" and "roughly pulled off their underwear and was put in their pyjamas". The note stated that Staff #234 was apprised of the complaint and in rebuttal stated: "nothing unusual occurred with resident's bedtime care, I did what I did every night, and I did nothing different tonight". Inspector #151 noted that the section on the form indicating what action was taken was left blank and that Staff #234 did not sign this form as per the requirement of the form. No other documentation found on the file in regards to this matter

23. MEMO TO THE DOC AND THE MANAGER OF HUMAN RESOURCES MARCH 9, 2011, BY STAFF #240-The memo stated that Staff #234 took a resident's call bell away because the resident was calling too many times. Removal of the call bell was witnessed by another staff member. The resident was very upset until Staff #240 returned the call bell to the resident. Staff #240 advised that there had been no time to address the issue with Staff #234 and requested the DOC or the HR Manager to follow up on it. The inspector did not find any further documentation on file in regards to this matter.

24. PROGRESS NOTE BY AN RPN DATED MARCH 16, 2011-recounts that upon arriving on the unit at 0030 h, Staff #234 advised that a resident had been ringing excessively and that the resident was yelling and quite agitated. The RPN went to the resident and the resident stated that Staff #234 took her call bell away and was none too gentle with the resident. The RPN gave the resident the call bell back. Inspector #151 did not find any further documentation on the file in regards to follow up.

25. LETTER OF DISCIPLINE DATED FEBRUARY 23, 2011, TO STAFF#234-The letter recounted that a resident experienced a responsive behaviour where the resident purposefully urinated on the floor and advised Staff #234 it was Staff #234's job to clean it up. It was alleged that Staff #234 put the resident back in the soiled brief and laid the resident back down on the resident's heavily urine soaked bed. Staff #234 documented the following that evening: "so I put on [the] brief and sorry but layed them back on their soiled bed and pikay" [pique incontinent/positioning sheet]. The home suspended Staff #234 pending investigation and upon return to the home required Staff #234 to repeat mandatory training in regards to Gentle Persuasion Approach and U-First.

26. MEMO FROM STAFF #215 TO THE DOC DATED SEPTEMBER 10, 2010-Staff #215 observed that Staff #234 was not following the resident's nutritional care plan by serving sugar free jam to all of the residents stating there was no time to check the dietary profiles. In addition, Staff #215 stated that Staff #234 served a resident requiring total assistance and took 15 minutes to return to assist the resident. When Staff #215 pointed out these things Staff #234 had a verbal altercation with Staff #215. Inspector #151 did not find any other documentation in regards to follow-up to the memo. In addition, Inspector noted that Staff #234's record indicated that the Licensee imposed restrictions to Staff #234's continued employment at the home.

Inspector #151 reviewed Staff #234's average hours of work per pay period for the last 3 months and noted that this employee worked an average of 105.08 hrs per pay. The Inspector audited Staff #234's assigned work location for the last 6 months and noted that Staff #234 had been assigned to one particular unit that they were not to work on, 6 times.

Inspector #151 interviewed resident #40336 who informed the inspector of an incident that occurred where a PSW refused a request to assist the resident to

the toilet and then to tell the resident to "jump out of bed and walk there myself". The Resident did state that they reported the incident to the RN Supervisor

The Inspector reviewed this resident's health care record and noted that the resident had a medical diagnosis that identified this resident as needing extensive assistance of 1 staff member for toileting, transferring, bathing and that resident's only way to mobilize was to use a wheelchair and self-propel. The Inspector noted that this resident was identified a high risk for falls.

The Inspector interviewed the RN Supervisor who confirmed that a report of the incident was filed and forwarded to the Director of Care on November 3, 2014.

The Inspector interviewed the Administrator and the Human Resources Manager, both of whom confirmed that they had no knowledge of the incident. The Administrator confirmed that no critical incident report was filed with the Ministry in regards to this allegation of staff to resident abuse as all of these reports go through him before being sent.

To summarize, staff #234 continues to demonstrate a pervasive pattern of performance concerns in relation to allegations and actual incidents of staff to resident abuse and/or neglect. This history of poor performance was documented in this staff member's personnel file. It was noted, dating as far back as 2010, staff #234 demonstrated inappropriate performance practices that included, but are not limited to abuse and neglect towards residents in the home, verbal altercations with other staff members and not providing care to residents as documented in their plan of care. Also identified in this staff member's personnel file, were numerous memos from other staff members outlining concerns relative to staff #234's conduct towards residents. As well, several "Notice of Action Required Forms" were filed with respect to staff #234's improper conduct. This staff member received numerous, one or three day suspensions, and a memo from the Director of Care indicated that repeat incidents would result in termination. This staff member remains an employee in the home.

As mentioned, dating back to 2010 and continuing through to November 2014, documented evidence verified little to no action was taken to protect the residents in the home. Therefore, the licensee's application of its disciplinary process and corrective interventions, were ineffective in preventing further recurrence of abuse and neglect of residents by staff #234.

Consequently, the licensee failed to ensure that residents are protected from abuse and neglect by the licensee or staff in the home.
(151)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Mar 13, 2015

Ontario

Ministry of Health and Long-Term Care

Order(s) of the Inspector
Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007,* S.O. 2007, c.8

Ministére de la Santé et des Soins de longue durée

Ordre(s) de l'inspecteur
Aux termes de l'article 153 et/ou de l'article 154 *de la Loi de 2007 sur les foyers de soins de* longue durée, L.O. 2007, chap. 8

Order # / Ordre no : 004

Order Type / Genre d'ordre : Compliance Orders, s. 153. (1) (a)

Pursuant to / Aux termes de :

LTCHA, 2007 S.O. 2007, c.8, s. 6. (7) The licensee shall ensure that the care set out in the plan of care is provided to the resident as specified in the plan. 2007, c. 8, s. 6 (7).

Order / Ordre :

The licensee shall ensure:

-that all staff provide care to residents as specified in their plan of care

Grounds / Motifs :

1. On November 20, 2014 Inspector #580 reviewed the Home's Nourishment policy 05-01-28 dated August 2014 which indicates that the dietary staff prepares any special therapeutic supplements ordered by the Registered Dietitian or Dietary Supervisor, that residents will be monitored during snacks, will be provided with personal assistance and encouragement required to safely drink, that the residents' intake is recorded, that when residents consistently refuse their snacks, especially those that have been specifically ordered, staff must communicate this information to the Dietary Supervisor and RD so that modifications/changes can be made.

On November 14, 2014 Inspector #580 reviewed the care plan for resident #00862 which indicates that the resident is to receive ½ an Ensure in the pm (the afternoon) to be provided by dietary, nursing staff to wake and assist this resident to drink it and that this resident is to receive a whole Ensure at hs (the evening), and that this was last reviewed by the Registered Dietitian on August 20, 2014 in the progress notes.

On November 19, 2014 staff #222, the Registered Dietitian confirmed to Inspector #580 that the nutritional supplements Ensure and Boost are used interchangeably at the home, that resident #00862 is to receive Resource 2.0 OD at HS med pass to be given by registered staff and documented in the MAR when given. This resident is to receive ½ an Ensure in the afternoon by dietary staff and if resident #00862 is sleeping, dietary staff are to give it to nursing staff who will awaken the resident and give the Ensure. This resident is also to receive a whole Ensure in the evening. On November 19, 2014 staff #222 confirmed that there is no documentation of Ensure or Boost being given to resident #00862 and that the staff are not waking them if they are asleep in order to give them the Ensure or Boost as per care plan direction.

On November 17, 2014 Inspector #580 reviewed the home's Nourishment Intake Record which indicated that resident #00862 received the afternoon ½ Boost/Ensure 4/16 or 25% of the specified times and received the evening full Boost/Ensure 1/16 or 6% of the specified times.

The licensee failed to ensure that the care set out in the plan of care was provided to the resident as specified in the plan. (580)

Ontario

Ministry of Health and Long-Term Care

Order(s) of the Inspector
Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007,* S.O. 2007, c.8

Ministére de la Santé et des Soins de longue durée

Ordre(s) de l'inspecteur
Aux termes de l'article 153 et/ou de l'article 154 *de la Loi de 2007 sur les foyers de soins de* longue durée, L.O. 2007, chap. 8

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Mar 13, 2015

Order # / Ordre no : 005

Order Type / Genre d'ordre : Compliance Orders, s. 153. (1) (a)

Pursuant to / Aux termes de :

LTCHA, 2007 S.O. 2007, c.8, s. 6. (8) The licensee shall ensure that the staff and others who provide direct care to a resident are kept aware of the contents of the resident's plan of care and have convenient and immediate access to it. 2007, c. 8, s. 6 (8).

Order / Ordre :

The licensee shall ensure:

-that all staff are kept aware of the residents plan of care, and

-that all staff have access to residents current plan of care

Grounds / Motifs :

1. On November 14, 2014, Inspector #580 spoke with the RN who confirmed that registered staff and the PSWs use the care plan for resident care information, that the care plans are located at the nursing station in a large binder and that this process is the same on each Home Area. On November 17, 2014, Inspector #543 spoke with the RAI coordinator who confirmed that all staff have access to all residents' care plans and that these care plans are located in binders on each unit. The RAI coordinator expressed concerns regarding communication amongst staff and updating care plans accordingly and that at times, care plans are updated in the computer but not on the paper care plans that are kept on the units. Therefore, errors in care provided to residents can occur.

On November 14, 2014, Inspector #580 spoke with the HCA who confirmed that staff get resident care information and direction from the care plan, from conversation with residents and from the resident's body language. In terms of communication needs for resident #00286, the HCA communicates with them face to face, but does not know what the care plan states about communication needs. On November 17, 2014, the RPN confirmed that they get care direction from the care plan. In terms of communication for resident #00286 the RPN

stated that this resident is understandable, speaks and answers with yes or no, tells staff what they need and does not wear hearing aids.

On November 14, 2014, Inspector #580 reviewed the health care record for resident #00286 including the care plan for the communication focus which stated that staff are to use non-verbal communication such as touch, facial expression, eye contact, tone of voice and posture to communicate, speak slowly using a low tone of voice, use short, direct phrases.

On November 17, 2014, Inspector #580 spoke with the RPN who confirmed that they look at the care plan for care direction, that there are no communications issues with resident #00862, that this resident speaks their mind and is clear with understanding, but the RPN was not sure of specific communication direction in the care plan and was not able to find any information in the care plan about communication, did not mention a hearing aid when asked about hearing aids for this resident. On November 17, 2014, Inspector #580 spoke with the HCA who confirmed that resident #00862 is good at communicating with staff, but was not sure what the care plan stated about communications and did not mention a hearing aid when asked about hearing aids for this resident.

Inspector #580 reviewed the health care record for resident #00862 including the care plan for the communication focus which stated that staff are to use short, direct phrases when speaking with the resident, and that they have a hearing aid that is used regularly.

On November 14, 2014, Inspector #580 spoke with the HCA who confirmed that staff get resident care information and direction from the care plan, from conversation with residents and from the resident's body language, and that communication needs for resident #20609. They confirmed the resident can converse and has no hearing aids, but does not know what the care plan states about communication needs. On November 17, 2014, the Inspector spoke with the RPN who confirmed that they get direction from the care plan, that related to focus of communication, resident #20609 is usually good to understand things but it depends on the day. When asked what the care plan specifically states regarding the communication needs of resident #20609, the RPN confirmed that they would have to look it up in the care plan, and that the resident does not wear hearing aids.

On November 14, 2014, Inspector #580 reviewed the health care records for

resident #20609 including the care plan for the communication focus which states the resident is hearing impaired in the right ear, has difficulty finding words or finishing thoughts, and staff are to use short, direct phrases when speaking with the resident, that staff are to use alternative methods of communications like the Bliss Board to communicate, encourage non-verbal language and ensure the hearing aid is functioning and in place.

On November 14, 2014, Inspector #580 spoke with the HCA who confirmed that staff get resident care direction from information posted on the walls in residents' rooms, on the resident care flow sheet, in speaking with the residents and by knowing the residents from having worked at the home for over five years. Regarding the communication needs for resident #40074, the HCA stated that they speak near to them, use short phrases so that the resident understands and did not mention a hearing aid when asked about hearing aids for this resident. On November 17, 2014, the Inspector spoke with the RPN who confirmed that they look at the care plan for care direction, that there are no communication issues with resident #40074, that this resident can communicate but her memory is "off", did not mention a hearing aid when asked about hearing aids for this resident and the RPN was not sure of specific communication direction in the care plan.

On November 14, 2014 Inspector #580 reviewed the health care records for resident #40074 including the care plan for the communication focus which stated that the resident is hard of hearing/wears aids, has minimal difficulty hearing when not in a quiet setting, repeats themselves/asking the same questions often and to therefore use short, direct phrases when speaking with them, to use alternative methods of communication, for example utilize a Bliss Board when communicating with the resident, that the resident has to reflect before answering, wears special apparatus to watch TV, and staff are to ensure that the hearing aid is functioning and in place.

On November 14, Inspector #580 spoke with the HCA who confirmed that staff get resident care information and direction from the care plan, from conversation with residents and from the resident's body language. In terms of resident #40186's communication needs, the HCA does not believe this resident has any communication concerns or needs, but does not know what the care plan states. On November 17, 2014, the Inspector spoke with the RPN who confirmed that they get care direction from the Care Plan, that related to focus of communication, resident #40186 speaks well, understands everything. When the

HCA was asked what the care plan specifically stated regarding the communication needs of resident #40186, the RPN stated that they would have to look it up in the care plan, but this resident is not deaf or hard of hearing and does not wear hearing aids.

On November 14, 2014 Inspector #580 reviewed the health care records for resident #40186 including the care plan for the communication focus which states that the resident is usually understood, searches for words, that staff are to encourage nonverbal communication, use short, direct phrases, encourage the resident to take their time, and hold conversation in quiet areas free of distraction.

On November 17, 2014, Inspector #580 spoke with the HCA who confirmed that they get care direction from the care plan, that resident #40820 does not speak, but was not sure what the care plan stated regarding communication needs for this resident. On November 17, 2014, the Inspector spoke with the HCA who confirmed that they get care direction from the care plan, that resident #40820 understands all, that staff explain care to the resident as they do it, but does not know what the care plan states exactly.

Inspector #580 reviewed the health care records for resident #40820 including the care plan for the communication focus which stated that this resident no longer wears hearing aids, talks very little, is rarely or never understood and rarely or never understands, to maintain eye contact when speaking with resident, to use short, direct phrases, to use non-verbal communication such as touch, facial expression, eye contact, tone of voice and posture, to maintain a quiet, non-distracting environment, encourage the resident to take their time.

On November 17, 2014, Inspector #580 spoke with the PSW who confirmed that they get care direction from the "nursing plan book" but was not sure what care needs resident #60621 required. The Inspector spoke with another HCA who confirmed that they get care direction from the care plan but was not sure about care plan specifics for resident #60621 but confirmed that resident #60621 can tell staff what they need.

On November 14, 2014 Inspector #580 reviewed the health care records for resident #60621 including the care plan for the communication focus which stated the resident is hard of hearing when not in a quiet setting, that they are usually understood, has difficulty finding words or finishing thoughts, and that

staff are to encourage non-verbal communication and use short, direct phrases.

On November 17, 2014, Inspector #580 spoke with the HCA who confirmed that they get care direction from the care plan, that resident #80041 has no issues with communication, did not mention a hearing aid when asked about hearing aids for this resident and was not sure what the care plan stated. On November 17, 2014, the HCA confirmed that they get care direction from the care plan, that resident #80041 is quiet, needs to be reminded, convinced and encouraged verbally and cared for one-on-one, did not mention a hearing aid when asked about hearing aids for this resident and was not sure what the care plan stated.

On November 14, 2014, Inspector #580 reviewed the health care records for resident #80041 including the care plan for the communication focus which stated that this resident can communicate in English and French, has episodes of disorganized speech, staff are to use short, direct phrases, and staff are to ensure the hearing aid is functioning and in place.

On November 17, 2014, the HCA spoke with the Inspector and confirmed that she gets care direction from the care plan, that resident #80274 has memory loss and needs to be reminded of things but was not sure what the care plan stated specifically. On November 17, 2014, the HCA confirmed that they get care direction from the care plan, that resident #80274 speaks and asks when they require something, but was not sure what the care plan stated specifically regarding communication.

Inspector #580 reviewed the health care records for resident #80274 the care plan for the communication focus stated that staff are to encourage nonverbal communication, use short direct phrases, encourage resident to take their time, and rely on yes and no questions.

Consequently, the licensee failed to ensure that the staff and others who provide direct care to a resident are kept aware of the contents of the resident's plan of care. (580)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Mar 13, 2015

Order # / Ordre no : 006

Order Type / Genre d'ordre : Compliance Orders, s. 153. (1) (a)

Pursuant to / Aux termes de :

O.Reg 79/10, s. 98. Every licensee of a long-term care home shall ensure that the appropriate police force is immediately notified of any alleged, suspected or witnessed incident of abuse or neglect of a resident that the licensee suspects may constitute a criminal offence. O. Reg. 79/10, s. 98.

Order / Ordre :

The licensee shall ensure:

-that the appropriate police force is immediately notified of any alleged, suspected or witnessed incident of abuse and/or neglect of a resident that the licensee suspects may constitute a criminal offence

Grounds / Motifs :

1. The Ministry received a Critical Incident reporting an allegation of staff to resident abuse which was inspected during the Resident Quality Inspection. Inspector #151 reviewed staff #234's personnel file and noted that documentation on file identified a history of allegations of resident abuse and neglect. The Inspector noted that despite the licensee's application of its disciplinary process and remedial interventions, the licensee did not protect residents from abuse specifically by staff #234.

Upon review of staff #234's personnel file, inspector #155 identified that in February 2013 a three day suspension was issued to this staff member for allegations of hitting a resident in a chopping motion on the left upper arm. This staff member "was seen to pull backwards on the resident's thumb". There were photos of the resident's injury, bruising to their arm, these photos were attached to the letter of reprimand in the staff member's file. Inspector #151 confirmed that the home did file a Critical Incident report with the Ministry regarding this matter.

Inspector #543 reviewed that critical incident report and determined that the licensee did not notify the appropriate police force.

Consequently, the licensee failed to ensure that the appropriate police force was immediately notified of any alleged, suspected or witnessed incident of abuse or neglect of a resident that the licensee suspects may constitute a criminal offence. (543)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Mar 13, 2015

REVIEW/APPEAL INFORMATION

TAKE NOTICE:

The Licensee has the right to request a review by the Director of this (these) Order(s) and to request that the Director stay this (these) Order(s) in accordance with section 163 of the Long-Term Care Homes Act, 2007.

The request for review by the Director must be made in writing and be served on the Director within 28 days from the day the order was served on the Licensee.

The written request for review must include,

(a) the portions of the order in respect of which the review is requested;
(b) any submissions that the Licensee wishes the Director to consider; and
(c) an address for services for the Licensee.

The written request for review must be served personally, by registered mail or by fax upon:

Director
c/o Appeals Coordinator
Performance Improvement and Compliance Branch
Ministry of Health and Long-Term Care
1075 Bay Street, 11th Floor
TORONTO, ON
M5S-2B1
Fax: 416-327-7603

When service is made by registered mail, it is deemed to be made on the fifth day after the day of mailing and when service is made by fax, it is deemed to be made on the first business day after the day the fax is sent. If the Licensee is not served with written notice of the Director's decision within 28 days of receipt of the Licensee's request for review, this(these) Order(s) is(are) deemed to be confirmed by the Director and the Licensee is deemed to have been served with a copy of that decision on the expiry of the 28 day period.

The Licensee has the right to appeal the Director's decision on a request for review of an Inspector's Order(s) to the Health Services Appeal and Review Board (HSARB) in accordance with section 164 of the Long-Term Care Homes Act, 2007. The HSARB is an independent tribunal not connected with the Ministry. They are established by legislation to review matters concerning health care services. If the Licensee decides to request a hearing, the Licensee must, within 28 days of being served with the notice of the Director's decision, give a written notice of appeal to both:

Health Services Appeal and Review Board and the Director

Attention Registrar
151 Bloor Street West
9th Floor
Toronto, ON M5S 2T5

Director
c/o Appeals Coordinator
Performance Improvement and Compliance Branch
Ministry of Health and Long-Term Care
1075 Bay Street, 11th Floor
TORONTO, ON
M5S-2B1
Fax: 416-327-7603

Upon receipt, the HSARB will acknowledge your notice of appeal and will provide instructions regarding the appeal process. The Licensee may learn more about the HSARB on the website www.hsarb.on.ca.

RENSEIGNEMENTS SUR LE RÉEXAMEN/L'APPEL

PRENDRE AVIS

En vertu de l'article 163 de la Loi de 2007 sur les foyers de soins de longue durée, le titulaire de permis peut demander au directeur de réexaminer l'ordre ou les ordres qu'il a donné et d'en suspendre l'exécution.

La demande de réexamen doit être présentée par écrit et est signifiée au directeur dans les 28 jours qui suivent la signification de l'ordre au titulaire de permis.

La demande de réexamen doit contenir ce qui suit :

a) les parties de l'ordre qui font l'objet de la demande de réexamen;
b) les observations que le titulaire de permis souhaite que le directeur examine;
c) l'adresse du titulaire de permis aux fins de signification.

La demande écrite est signifiée en personne ou envoyée par courrier recommandé ou par télécopieur au:

Directeur
a/s Coordinateur des appels
Direction de l'amélioration de la performance et de la conformité
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Ontario, ON
M5S-2B1
Fax: 416-327-7603

Les demandes envoyées par courrier recommandé sont réputées avoir été signifiées le cinquième jour suivant l'envoi et, en cas de transmission par télécopieur, la signification est réputée faite le jour ouvrable suivant l'envoi. Si le titulaire de permis ne reçoit pas d'avis écrit de la décision du directeur dans les 28 jours suivant la signification de la demande de réexamen, l'ordre ou les ordres sont réputés confirmés par le directeur. Dans ce cas, le titulaire de permis est réputé avoir reçu une copie de la décision avant l'expiration du délai de 28 jours.

En vertu de l'article 164 de la Loi de 2007 sur les foyers de soins de longue durée, le titulaire de permis a le droit d'interjeter appel, auprès de la Commission d'appel et de révision des services de santé, de la décision rendue par le directeur au sujet d'une demande de réexamen d'un ordre ou d'ordres donnés par un inspecteur. La Commission est un tribunal indépendant du ministère. Il a été établi en vertu de la loi et il a pour mandat de trancher des litiges concernant les services de santé. Le titulaire de permis qui décide de demander une audience doit, dans les 28 jours qui suivent celui où lui a été signifié l'avis de décision du directeur, faire parvenir un avis d'appel écrit aux deux endroits suivants :

À l'attention du registraire
Commission d'appel et de révision des services de santé
151, rue Bloor Ouest, 9e étage
Toronto (Ontario) M5S 2T5

Directeur
a/s Coordinateur des appels
Direction de l'amélioration de la performance et de la conformité
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Ontario, ON
M5S-2B1
Fax: 416-327-7603

La Commission accusera réception des avis d'appel et transmettra des instructions sur la façon de procéder pour interjeter appel. Les titulaires de permis peuvent se renseigner sur la Commission d'appel et de révision des services de santé en consultant son site Web, au www.hsarb.on.ca.

Issued on this 19th day of February, 2015

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : Tiffany Boucher

Service Area Office /
Bureau régional de services : Sudbury Service Area Office